Kathirvelu v Pacific & Orient Insurance Co Sdn Bhd

HIGH COURT (JOHORE BAHRU) — CIVIL SUIT NO 841 OF 1985
LC VOHRAH J
7 JUNE 1990

Insurance — Personal accident insurance — Claim for permanent and total disability and indemnity for medical expenses — Repudiation by insurers — Whether plaintiff was permanently and totally disabled — Non-disclosure of material facts — Whether there was breach of condition to inform insurer of accident within 14 days

The plaintiff, aged 54 years, suffered a swelling to his hand on 29 October 1983 as a result of a fall down the stairs. On 19 November 1983, he was involved in a motor vehicle accident whereby he sustained an injury to the same hand. Upon prolonged treatment for the injury, the plaintiff was finally diagnosed as suffering from Sudeck's osteodystrophy on 30 October 1984. However, the combined effect of this ailment, the different medication prescribed for the treatment of the plaintiff's condition and the severe stress he underwent after the accident resulted in other ailments and complications. On 27 December 1983 (38 days after the second accident), the plaintiff made a claim under a personal accident insurance policy issued by the defendant for payment of a liquidated sum of $200,000 for total disablement and an indemnity in respect of medical expenses amounting to $2,250. The plaintiff had previously stated in the insurance proposal form that he was not suffering from certain ailments as well as 'any other disease'. He further signed a declaration on the proposal form that his answer to the question of ailments and any other disease was to form the basis of the contract of insurance. The defendant then denied liability on the ground the plaintiff's bodily injury did not result in permanent total disablement; repudiated liability on the ground of non-disclosure of material facts (namely, that at the time of executing the insurance proposal form the plaintiff was allegedly suffering from various diseases which he did not disclose); and that there was a breach of a condition of the policy that required notice to be given to the defendant within 14 days of any accident that was likely to give rise to a claim.

Held, allowing the plaintiff's claim:

(1) Permanent disablement as opposed to temporary disablement must mean permanent total disablement which prevents a person from engaging in or giving attention to 'profession or occupation of any kind'. The test for this should be whether he was fit to attend to business and play a worthwhile part in the conduct of his own or some substituted type of business.

(2) Having regard to the evidence of the expert medical witness that the plaintiff's 'condition certainly condemns him to be totally and permanently disabled', and having seen the physical disability of the plaintiff manifest itself during the trial in the constant uncontrollable nervous twitching and flapping of the right arm, the bodily injury suffered by the plaintiff from the two accidents has resulted in his permanent total disablement from engaging in or giving attention to his occupation or to any substituted type of occupation.

(3) With regard to the non-disclosure of material facts, the plaintiff's admission that before both accidents he had sought medical advice for the pain in his neck described as 'early cervical spondylosis' cannot be considered positive evidence that the plaintiff was in fact suffering from cervical spondylosis. Having regard to the ejusdem generis rule it is doubtful whether this condition would have required disclosure as 'any other diseases' in the proposal form. As to the other ailments (haemorrhoids, labile hypertension and peptic ulcers), there was a difference in opinion from various expert medical witnesses as to when these ailments actually arose.

(4) On the evidence presented, both oral and documentary, there was nothing to suggest that the plaintiff was suffering from the four conditions, or knew or had reason to know that he was suffering from them when he signed the proposal form. That being the case, the defendant was not entitled to repudiate the policy on the ground of non-disclosure of material facts.

(5) As to the alleged breach of a condition of the policy concerning notice, the requirement of the policy is to give notice of an accident that was likely to give rise to a claim on the part of the insured, ie one causing an injury that could be considered sufficiently serious to give rise to a claim under the policy and not of any and every accident, however trivial, that the plaintiff might be involved in.

(6) The plaintiff only informed the defendant of the two accidents beyond the 14-day period when he realized that the injury to his arm could give rise to a claim. As such he cannot be said to have breached the condition of the policy concerning notice so as to disentitle him from making this claim. The language of the condition is clear and unambiguous, and upon a natural construction of the provisions, the defendant is not entitled to repudiate the plaintiff's claim on the ground of breach of the condition.

(7) Judgment in favour of the plaintiff in the sum of $200,000 for permanent disablement and the agreed sum of $2,250 as indemnity for the cost of medical and surgical treatment incurred, with interest at 4% pa from the date of repudiation. The plaintiff is entitled to recover his costs in this suit.

[*Editorial Note*: The defendant has appealed to the Supreme Court vide Civil Appeal No 02-296-90.]

Cases referred to

1 *Pocock* v *Century Insurance Co Ltd* [1960] 2 Lloyd's Rep 150 (folld)
2 *Cassel* v *The Lancashire and Yorkshire Accident Insurance Co (Ltd)* (1885) 1 TLR 495 (refd)

N Jegatheeson for the plaintiff.
RA Kumar for the defendant.

Cur Adv Vult

LC Vohrah J: This is a claim under a personal accident insurance policy issued by the defendant for repayment of a liquidated sum of $200,000 for total disablement and also indemnity in respect of medical expenses amounting to $2,250.

The defendant has denied liability on the ground that there was non-disclosure of material facts, that there was a breach of condition of the policy and that the plaintiff's condition does not fall within the ambit of the policy.

The plaintiff, now aged 54 years, until he was medically boarded out at the instance of the state government on 1 December 1984, was a superscale technical assistant in the Jabatan Kerja Raya in the state of Johor having

technical charge of the hospitals and markets in Muar and responsibility for the construction of the ammunition depot in Kluang. Since 1977 he had been taking out personal accident policies on a yearly basis with the defendant. The policy ABD 1-4 on which the present claim is founded was issued by the defendant on 17 June 1983 and it covered the period 19 June 1983 to 18 June 1984 and provided, inter alia, for the payment to the plaintiff of the sum of $200,000 for bodily injury 'caused by violent accidental external and visible means which injury shall solely and independently of any other cause result in' permanent disablement occurring within 24 calendar months of such bodily injury and of a sum up to $5,000 by way of indemnity for expenses incurred for medical and surgical treatment for the injury 'in respect of any one accident'. The said policy was issued pursuant to the proposal form 'D1' signed by the plaintiff on 14 June 1983, question no 10(a) of which required an answer as to whether the plaintiff to the best of his knowledge suffered from any of the diseases listed therein 'or any other disease' and the answer was 'no'. All the answers and other particulars in D1 were entered by an agent of the defendant after the plaintiff had signed the blank form. During the currency of the said policy the plaintiff met with two accidents — the first occurring on 29 October 1983 when he fell down the stairs at the Johore Bahru General Hospital and suffered a swelling in his right hand and the second on 19 November 1983 when he was involved in a motor vehicle accident whereby he sustained an injury also to the same hand. In respect of the first accident the plaintiff was treated at the Johore Bahru hospital and given medical leave for a fortnight until he reported for work on 12 November 1983. In respect of the second accident he was given medical leave for 6 days. Despite the medication prescribed for his injured right hand the swelling did not subside. Then by letter dated 27 December 1983 (ABD 13), written 38 days after the second accident, the plaintiff informed the defendant of the two accidents. The defendant by letter dated 11 January 1984 (ABD 14) acknowledged its receipt and forwarded a three-page claim form (ABD 19) for completion and return within 14 days by the plaintiff; the last page entitled 'Medical Certificate' required the answers to the questions therein to be furnished by a registered medical practitioner and question no 7 in particular required the doctor to state whether the plaintiff sustained any permanent disability. In the meanwhile the plaintiff's condition worsened and he was admitted to the Johore Bahru hospital as an in-patient on three separate occasions — on 17 April 1984, 19 June 1984 and 17 July 1984. On 30 August 1984, the claim form duly completed was returned to the defendant with the answer of the orthopaedic registrar to question no 7 as 'still in the ward under treatment'. None of the three specialists at the Johore Bahru hospital who attended upon the plaintiff was able to diagnose the plaintiff's ailment until 30 October 1984 when they certified that he was suffering from, inter alia, Sudeck's osteodystrophy after a meeting convened at the instance of the state government whereat he was recommended to be boarded out (see ABD 35). The diagnosis of Sudeck's osteodystrophy was arrived at by a process of elimination as it is a very rare condition resulting from damage to the peripheral nerve. It is a disease for which there is no known remedy. In the case of the plaintiff it causes pain, swelling of the joints and osteoporosis in the affected arm as a result of which he suffers from emotional distress. It also prevents the plaintiff from using his right hand altogether and has also affected other areas of the plaintiff's body, causing stiffness in the joints of his left elbow and left shoulder. The different medications prescribed for the treatment of the plaintiff's condition and the severe stress he underwent after the accidents resulted in other ailments manifesting themselves, namely oesophangitis, duodenitis and seronegative arthritis apart from aggravating the first degree haemorrhoids, the cervical spondylosis and the labile hypertension which the plaintiff had been suffering from quite unbeknown to him. Until the time when the three specialists recommended on 30 October 1984 that he be medically boarded out with effect from 1 December 1984, the plaintiff had been on medical leave. A copy of this recommendation was forwarded to the defendant by the plaintiff's solicitors through their letter dated 31 December 1984 (ABD 27). Prior to this, however, by letter dated 18 October 1984 (ABD 24) the defendant repudiated liability in respect of the plaintiff's claim arising out of the first accident on 29 October 1983 on the ground that it had not been notified of the accident within the period stipulated in the policy, ie 'within 14 days after the happening of the accident'. By another letter dated 29 July 1985 (ABD 29) the solicitors for the defendant wrote to the solicitors for the plaintiff repudiating the policy for the second accident on 19 November 1983 on the ground of the defendant's failure to notify the defendant of the accident within the prescribed time and additionally on the ground of non-disclosure of material facts by the plaintiff 'whilst completing the proposal form'.

So much for the facts established by the plaintiff. In the absence of any evidence adduced on behalf of the defendant three issues were formulated and agreed upon by counsel for determination by the court and they were:

(1) Has the plaintiff suffered bodily injury which has resulted in permanent total disablement as defined in the policy?

(2) Is the defendant entitled to repudiate the said policy on the ground of non-disclosure of material facts at the time of executing the proposal form in that the plaintiff failed to disclose that he was then allegedly suffering from various diseases?

(3) Is the defendant entitled to repudiate the plaintiff's claim on the ground of breach of policy condition, ie condition no 7 which requires notice to be given to the

defendant within fourteen (14) days of any accident that is likely to give rise to a claim?

I shall now proceed to deal with the issues one by one.

Issue No 1

The relevant table of benefits of the policy provides:

Bodily injury caused by violent accidental external and visible means which injury shall solely and independently of any other cause result in:

A Death — occurring within 24 calendar months of bodily injury as aforesaid $200,000

B Permanent disablement occurring within 24 calendar months of bodily injury as aforesaid and not followed within 24 calendar months of the said bodily injury by the death of the insured $200,000

C1 Total disablement temporarily from engaging in or giving attention to profession or occupation: Compensation for such disablement at the rate of ..... $100 per week

C2 Partial disablement temporarily from engaging in or giving attention to profession or occupation: Compensation for such disablement at the rate of ..... $50 per week

or necessitate:

D Medical and surgical treatment for such injury: Indemnity for the expenses of such treatment incurred by the insured subject to a limit in respect of any one accident of $5,000

Provisos

(a) Compensation under benefits C1 and C2 either separately or together shall not be payable for a longer period than 104 weeks in respect of any one injury calculated from the date the insured was first examined by a duly qualified medical practitioner.

(b) The insured shall not for the purpose of this policy be considered partially disabled under benefit C2 when able to attend to some extent to his profession or occupation but unable to attend to substantial part thereof.

(c) Compensation shall be payable only when the claim shall have been proved to the satisfaction of the company.

It is clear from the medical evidence adduced that the onset of Sudeck's osteodystrophy resulting in the plaintiff's physical disability was caused by the injury to his right arm in direct consequence of the two accidents he was involved in within a short space of one another — the fall at the hospital he sustained on 29 October 1983 and the motor accident he met with on 19 November 1983. This physical disability took the form of the constant twitching and flapping of his whole right arm which was obvious throughout the period of the trial when the plaintiff was in court. Sudeck's osteodystrophy was certified by the medical board of three consultants of the General Hospital on 30 October 1984 as the first of even ailments which rendered him unfit to perform his duties as a technical assistant and also to perform other duties well within 24 months of the first accident. The board also recommended that he be deemed unfit permanently and that he undergo treatment at the orthopaedic clinic, the medical clinic and the surgical clinic monthly and, in addition, to undergo physiotherapy treatment daily. The question I have to consider is whether his physical disability arising from Sudeck's osteodystrophy caused him permanent disablement within the meaning of the policy to qualify for the payment of $200,000, a sum payable also in the event of death from bodily injury. The policy in a separate interpretation section at ABD2 differentiates disablement into three categories, 'Permanent Total Disablement', 'Temporary Total Disablement' and 'Temporary Partial Disablement' in descending order of severity and defines 'Permanent Total Disablement' as 'absolute disablement from engaging in or giving attention to profession or occupation of any kind'; 'Temporary Total Disablement' as 'disablement from engaging or giving attention to any portion of the insured's ordinary profession or occupation'; and 'Temporary Partial Disablement' as 'partial disablement from engaging or giving attention to the insured's ordinary profession or occupation'. There can be no doubt that the plaintiff's disablement is not temporary but permanent in nature. As a matter of commonsense and applying the contra proferentem rule, I take the view, having regard to the definitions given, that permanent disablement as opposed to temporary disablement must mean permanent total disablement which prevents a person from engaging in or giving attention to 'profession or occupation of any kind'. Having regard to the submission of counsel for the defendant that the plaintiff ought to seek or ought to have sought alternative employment in 'a desk (sedentary) job' to suit his present condition, what meaning then do I have to attribute to the phrase 'profession or occupation of *any kind*'? Of the authorities that have been submitted for consideration by the court, the case of *Pocock* v *Century Insurance Co Ltd*[1] has direct relevance as it turns on the interpretation of comparable words. In that case Pocock claimed payment of money allegedly due under an accident insurance policy. Under cl (f) of the benefits payable under the policy there was the provision that the insurers for 'temporary total disablement from attending to business of *any and every kind*' should pay 'benefit for the duration of such disablement at the weekly rate of £20' and under cl (g) for 'temporary partial disablement, that is disablement from attending to some material portion of his usual business or occupation', the insurers should pay 'benefit for the duration of such partial disablement at the weekly rate of £6'. The business or profession of Pocock was stated in the policy to be that of a wholesale grocer but he was in fact the manager of the grocery business, the character of which was described as

that of a jobbing buyer. His practice was to drive all over the country buying job lots of grocery where opportunity offered and then disposing of that which he had bought cheaply at markets and stalls. On 6 March 1957 Pocock became totally disabled as the result of a motor car accident and the issue in the action was concerned with the period for which the higher rate representing total disablement should be paid. Pocock claimed that this rate should endure until 6 September 1958 whereas the insurers, having made certain payments under the policy on the basis of total disablement, contended that it was terminated on 17 August 1957. Counsel for Pocock contended that the phrase in cl (f), 'business of any and every kind', must be looked at as a whole and in its context and that the question was whether Pocock was fit to go to business. Counsel for the insurers contended that the phrase meant what it said and that if, as happened in this case, a man made entries in books, that was an aspect of business, and, even if it was comparatively unimportant to the running of a business as a whole, it was nevertheless a part of business which was covered by the phrase 'business of any and every kind'; if Pocock was capable of any part-time effort in the way of any business, he was thereby deprived of his right to benefit for total disablement. It was held that the test was whether he was fit to attend to business and play a worthwhile part in the conduct of his own or some substituted type of business; the fact that he could do some trivial part of the business rather badly would not mean that he was capable of attending to business or that he was not totally disabled. Commissioner Molony QC had this to say (at p 153):

> Mr Scott's [counsel for the insurers'] contention, as I understand it, is that, if a man after an accident is capable of any part-time effort in the way of doing business, he is thereby deprived of his right to the full £20 a week. The phrase 'business *of any and every kind*' means, says Mr Scott, just what it says: it means, for example, that, if a man makes entries in books, as happened indeed in this case, that is an aspect of 'business' and, even if it is comparatively unimportant to the running of a business as a whole, it is nevertheless a part of business which is covered by the phrase 'business of any and every kind'.
>
> I do not accept that argument. I have not accepted it in fixing the date at 6 June 1958. I think, as Mr Dean [counsel for Pocock] contends, that *the phrase must be looked at as a whole and in its context*; and that what attention is directed to is attending to business of any sort, which might be that of a wholesale grocer doing the business nominated in this case or might be some substituted business to which a person might turn; and, in order to bring the clause into operation, the question is whether a man is fit to go to business, to use a vernacular expression. Is he able to attend to a business of the nominated or some substituted type? My view is that a person cannot be said to attend to business in that sense simply because he is capable of doing — perhaps rather badly — some minor part of the work involved in that or any other sort of business. (Emphasis added.)

In the light of the above interpretation, with which I agree, and having regard to the evidence of PW3, a consultant orthopaedic surgeon and former Associate Professor of orthopaedic surgery at the University of Malaya, to the effect that the plaintiffs 'condition certainly condemns him to be totally and permanently disabled', I am more than satisfied, after having also seen the physical disability of the plaintiff for the whole duration of the trial expressing itself in the constant uncontrollable nervous twitching and flapping of the right arm, that the bodily injury suffered by the plaintiff from the two motor accidents causing Sudeck's osteodystrophy has resulted in his permanent total disablement from engaging in or giving attention to his occupation or to any substituted type of occupation. In no way can the plaintiff in his present physical state be able to engage or give attention to his occupation as a technical assistant, an occupation which requires full control not only of one's mental faculties but also of one's limbs particularly the upper limbs. (In fact I cannot conceive of the plaintiff being capable in his present physical state of doing even some minor part of the work of a technical assistant). Any other occupation would, needless to say, be out of the question because the continual twitching and flapping of his right upper limb would clearly prevent him from concentrating on any job he might be engaged in. I therefore hold that the plaintiff has suffered bodily injury which has resulted in permanent total disablement as defined in the policy.

Issue No 2

Question 10(a) of the proposal form dated 14 June 1983 posed to the plaintiff the following question:

> Have you to the best of your knowledge and belief ever had hernia, cancer, epilepsy, vertigo, paralysis, tuberculosis, diabetes, any form of rheumatism, any disorder or disease of the mental, nervous, genito-urinary, digestive, cardio-vascular systems or any other disease.

The answer was 'no' and the plaintiff signed the declaration at the end of the proposal form as follows:

> I hereby apply for insurance against risks as set out in the company's 'Comprehensive' Personal Accident Policy and I hereby warrant that the above statements and particulars are true, and I declare that I have not withheld any information which is calculated to influence the decision of the company as to my eligibility for insurance and I agree that this proposal and declaration and the answers given shall be the *basis* of the contract between myself and the company, and I further agree to accept a policy subject to the usual conditions prescribed by the company therein, and to pay the first premium thereunder when called upon to do so. (Emphasis added.)

It is stated in Hardy Ivamy's *General Principles of Insurance Law* (2nd Ed) (at p 132), that where there is a 'basis' clause '[t]he usual declaration at the foot of the proposal form that the answers are true, and that they are to be the basis of the proposed contract of insurance makes the truth of the answers a condition precedent, and the proposed assured, by signing it, signifies his agreement

thereto'. Counsel for the defendant has attributed four ailments to the plaintiff prior to the signing of the proposal form, namely, (i) cervical spondylosis, (ii) haemorrhoids, (iii) labile hypertension and (iv) peptic ulcers. He argues that because these ailments were not disclosed by virtue of the negative answer to question 10(a) of the proposal form, this non-disclosure entitled the defendant to repudiate the policy.

I shall now proceed to examine the evidence to ascertain if the plaintiff did suffer or could be considered to have suffered from these four ailments before the proposal form was signed. It is submitted by the plaintiff in cross-examination and confirmed by the medical report BD 6-7 written by a surgical specialist in Singapore that in April 1981 the plaintiff sought medical advice for the pain in his neck described by the specialist as 'early cervical spondylosis'. I do not think this admission by the plaintiff and the description by the specialist can be considered as positive evidence that the plaintiff was in fact suffering from cervical spondylosis. In any event having regard to the ejusdem generis rule I doubt if it is a condition which would have required disclosure as 'any other disease' in the proposal form. Apart from this pain in the neck the plaintiff denied having suffered from any of the seven illnesses specified in the medical board's report at any time before his accident or when the policy was signed on 14 June 1983. The evidence and the medical report BD 15-16 of Dato (Dr) K Sarvananthan, a senior consultant physician of the General Hospital, Kuala Lumpur, who had attended on the plaintiff since 1977, indicate that the plaintiff had been perfectly well until his accident in 1983 except for a sensitive stomach which was prone to gastritis and he opined that the plaintiff must have suffered from haemorrhoids, cervical spondylosis and labile hypertension before the accidents. Mr S Shanmugam, a consultant surgeon who had also attended upon the plaintiff, testified that the plaintiff did not suffer from peptic ulcers or gastritis before the accidents but opined in his report that the plaintiff's first degree haemorrhoids or piles could have arisen before the accident. The third consultant called by the plaintiff, Dr K Thambyrajah, a consultant orthopaedic surgeon, in his testimony and in his report BD 9-10 indicated that the plaintiff's labile hypertension could certainly be accounted for by the distress and suffering that he had gone through as a result of the accidents. Dr A Annamalai, the consultant orthopaedic surgeon who was the third member of the medical board, in his report certified that he had not discerned cervical spondylosis as a condition that the plaintiff was suffering from prior to the first accident. In my view, on the evidence presented, both oral and documentary, there was nothing to suggest that the four conditions referred to by counsel for the defendant were conditions the plaintiff was suffering from or knew or had reason to know he was suffering from when he signed the proposal form. That being the case the defendant, in my judgment, is not entitled to repudiate the policy on the ground of non-disclosure of material facts.

Issue No 3

The relevant provision of condition 7 of the policy reads:

> Upon the happening of any accident *likely* to give rise to a claim under this policy the insured shall within 14 days after the happening of the accident give notice to the company with full particulars of the accident and injuries and shall as soon as possible procure and act on proper medical or surgical advice ... (Emphasis added.)

Counsel for the defendant contends that since the defendant was notified of the accident 38 days after the event the plaintiff was in breach of the above condition. I do not think so. I agree with counsel for the plaintiff that the requirement in the above provision is to give notice of an accident that was likely to give rise to a claim on the part of the insured, ie one causing an injury that could be considered sufficiently serious to give rise to a claim under the policy and not of any and every accident however trivial that the insured might be involved in. In his evidence the plaintiff stated in examination-in-chief:

> On 29 October 1983, I fell down from the stairs at the Johore Bahru Hospital leading from the roof to the first floor. It was a permanent staircase. I sustained injuries. I fell and sustained a swelling in my right hand. An x-ray was done and it revealed no fractures. I sustained no wound. I was given medical leave periodically for a period of two weeks. I went back to work on 12 November 1983. I did not report the accident to the insurance company because I got better within two weeks and I resumed work. On 19 November 1983 whilst on duty I met with a slight motor vehicle accident on the way to Muar. I did not suffer any serious injuries. I only suffered bruises on the same hand at the same place when I had the fall.

and in cross-examination:

> As a result of the first accident there was no injury except for the swelling. As a result of the second accident I suffered bruises ...
>
> After the two accidents I realized that there was something serious three weeks after the second accident when the pain was getting severe. I notified the defendant on 27 December 1983.

There has been no suggestion at all that the plaintiff was not a truthful witness and I accept his explanation that the reason why he notified the defendant by the letter ABD 13 of his two accidents beyond the 14-day period prescribed in condition 7 was because it was only after that period when the pain was getting worse that he realized there was something wrong with his right arm which could give rise to a claim. I cannot see how the plaintiff can be said to have breached condition 7 so as to disentitle him from making this claim. Counsel for the defendant has referred me to the case of *Cassel* v *The Lancashire and Yorkshire Accident Insurance (Ltd)*[2] where (according to the headnote) a policy of insurance against accidents contained a proviso that the assured should give the insurers notice of the occurrence

of the accident and of the injuries received within 14 days of the date of the accident. The assured met with an accident in July but was not aware that he had received injury until the following March when he at once gave notice to the insurers. In an action upon the policy it was held that the notice was not within the time limited by the policy and that therefore the assured was not entitled to recover. This case was reported in a very abbreviated form and the provisions of the proviso were not reproduced therein for any satisfactory comparison to be made. In any event the language of the relevant provision of condition 7 is, to my mind, clear and unambiguous and upon a natural construction of those provisions, I hold that the defendant is not entitled to repudiate the plaintiff's claim on the ground of breach of that condition.

In the result, I would give judgment in favour of the plaintiff for the sum of $200,000 for permanent disablement and the agreed sum of $2,250 as indemnity for the cost of medical and surgical treatment incurred with interest at 4% pa from the date of repudiation. The plaintiff is entitled to his costs in this suit.

Claim allowed.

Solicitors: *John Ang & Jega; Varughese Kumar Netto & Partners.*

Reported by *Azra Moiz*

Re Yamaha (Malaysia) Sdn Bhd

HIGH COURT (KUALA LUMPUR) — COMPANIES WINDING-UP NO 76 OF 1981
SITI NORMA YAAKOB J
2 FEBRUARY 1990

Contract — Accord and satisfaction — Debt owing by company — Creditor entering into arrangement with associate company regarding repayment of debt — Mortgages created over properties pursuant to arrangement — Properties sold — Proceeds utilized by creditor to settle other liabilities of associate company — Whether debt of company discharged — Contracts Act 1950, s 64

Civil Procedure — Limitation — Enforcement of judgment — Judgment obtained against company — Company wound up by order of court — Appeal by creditor against rejection by liquidator of proof of debt — Whether appeal a mode of enforcement — Date from which time runs — Companies (Winding-Up) Rules 1972, r 93 — Limitation Act 1953, ss 2, 3 & 6

Yamaha (Malaysia) Sdn Bhd was wound up by order of the court on 22 February 1982. The applicant, Indian Overseas Bank, lodged a proof of debt for the sum of $2,947,032.06 with the liquidator of the company. Relying on a statement by a director of the company, the liquidator had rejected the proof on the ground that the debt had already been paid. By a motion dated 18 April 1987, the applicant appealed to the court against the rejection of the proof. The applicant had granted credit facilities to an associate company in Singapore, part of which was used for the benefit of the company in the form of three bills of exchange. Following the dishonour of the bills, the applicant sued the company and obtained judgment on 19 May 1978 for the sum of $2,947,032.06. The applicant had also sued the associate company and six of its directors in Singapore for the recovery of all sums due under the facilities, which facilities included seven trust receipts and the three bills. The applicant obtained judgment in Singapore for the sum of $4,629,770.84 which sum included the sum due under the three bills. Following negotiations, in consideration of the applicant forebearing from executing the judgment obtained in Singapore, the associate company agreed to make monthly repayments towards the judgment debt and as security for this arrangement, certain properties were mortgaged to the applicant. Following a default by the associate company in making the payments, the applicant sold some of the properties and from the proceeds of sale and other payments, the total sum of M$3,656,655.80 was paid to account and which the director contended should have been utilized first towards settlement of the three bills, as liability on those bills had arisen earlier in point of time to the trust receipts.

The applicant's motion was also opposed by a contributory of the company, namely, Sucaba Holdings Bhd on the ground that there had been accord and satisfaction of the debt by the terms of the settlement reached in Singapore. Sucaba Holdings Bhd also contended that no arrears of interest could be claimed for the period prior to 18 April 1981 (being the date six years prior to the date of the filing of the motion) as the claim was barred by limitation, and relied on s 6(3) of the Limitation Act 1953. It was contended for the applicant that the motion was intended to enforce a judgment as opposed to the commencement of an action to enforce the judgment. It was also contended that the relevant limitation period was prescribed by r 93 of the Companies (Winding-Up) Rules 1972 upon which the motion was founded. The applicant further contended that any action to recover money secured by any mortgage or charge on land or personal property was outside the limitation period prescribed by s 6(1) of the Act and hence s 6(3) of the Act was not applicable.